

To be given to the individual  
examined with a pre-addressed  
envelope marked  
"Confidential - Medical".

**CERTIFICATE OF MEDICAL EXAMINATION**  
**U.S. OFFICE OF PERSONNEL MANAGEMENT**

Form Approved  
OMB No. 3206 - 0250

**Privacy Act Statement**

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals; Section 3301 of Title 5, United States Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge and ability; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

**Public Burden Statement**

We estimate an average of two to three hours per response to complete, including the time for reviewing instructions, getting needed information, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the U.S. Office of Personnel Management (OPM), Strategic Human Resources Policy, Medical Policy and Programs Division, Attn: OMB Number (3206-0250), 1900 E Street, NW, Washington, D.C. 20415. The OMB number, 3206-0250, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

**Instructions**

There are five parts in this form:

- Part A** - To be completed by applicant or employee. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.
- Part B** - To be completed by the appointing officer before the medical examination: identifies the purpose of the examination; the position title, series and grade; generally describes the position; and shows the specific functional requirements and environmental factors that the work requires.
- Part C** - To be completed and signed by the examining physician, and returned to the employing agency in the pre-paid/pre-addressed "Confidential-Medical" envelope provided.
- Part D** - To be completed by the agency medical officer who reviews the examination results and recommends action.
- Part E** - To be completed by the agency human resources officer in order to document the personnel action that is rendered.

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Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE		
1. Name (Last, First, Middle Initial)		
2. Federal Employee Number	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Birth Date ( <i>month, day, year</i> )
5. Do you have any medical disorder or physical impairment which would interfere in any way with the full performance of the duties shown in Part B, No. 3? <input type="checkbox"/> Yes <input type="checkbox"/> No  (If your answer is YES, explain fully to the physician performing the examination)		
6. Address (including City, State, Zip Code)		
7. E-mail Address	8. Telephone Numbers (with Area Code)	
9. Applicant or Employee Consent and Certification  I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.		
10. Signature (Do not print)	11. Date ( <i>month, day, year</i> )	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. (29 C.F.R. 1635.8(b)(1)(i)(B))

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**Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER**

<p>1. Purpose of examination</p> <p><input type="checkbox"/> Pre-placement</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>2. Position Title, Series, and Grade</p> <p>AUTOMOTIVE WORKER LEADER, WL-5823</p>
<p>3. Brief description of what the position requires the employee to do.</p> <p>Serves as working leader of three or more employees in accomplishing trades and labor work. The highest level of non-supervisory work led is Automotive Worker, WG-5823-09 (title, code, and grade).</p> <p>Passes on to other workers instructions received from supervisor, demonstrates proper work methods, and starts work. Insures that needed plans, blueprints, material and tools are available, and that needed stock is obtained from supply locations. Works along with other employees and sets pace performing non-supervisory work of the same kind and level as that done by the group led.</p> <p>Sees to it that there is enough work to keep everyone in work crews busy. Checks work in progress and when finished for compliance with supervisors instructions on work sequence, procedures, methods and deadlines, and urges or advises other employees to follow supervisors instructions and to meet deadlines. Answers workers questions regarding procedures, policies, written instructions, and other directives (e.g., technical orders). Provides information to supervisor on status and progress of work, causes of delays, and overall work operations and problems (e.g., additional on-the-job training requirements for individual employees).</p> <p>Assures that safety and housekeeping rules are followed (e.g., assures that machine capacities are not exceeded and that tools are properly used). Must possess valid state drivers license and be able to obtain a Government vehicle operators permit.</p>	

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**Part B. CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER**

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

**4a. Functional Requirements**

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Heavy lifting, 45 pounds and over   | <input checked="" type="checkbox"/> Repeated bending (____ hours)                             | <input checked="" type="checkbox"/> Both eyes required                      |
| <input type="checkbox"/> Moderate lifting, 15-44 pounds                 | <input type="checkbox"/> Climbing, legs only (____ hours)                                     | <input checked="" type="checkbox"/> Depth perception                        |
| <input type="checkbox"/> Light lifting, under 15 pounds                 | <input checked="" type="checkbox"/> Climbing, use of legs and arms                            | <input checked="" type="checkbox"/> Ability to distinguish basic colors     |
| <input checked="" type="checkbox"/> Heavy carrying, 45 pounds and over  | <input checked="" type="checkbox"/> Both legs required  | <input checked="" type="checkbox"/> Ability to distinguish shades of colors |
| <input type="checkbox"/> Moderate carrying, 15-44 pounds                | <input checked="" type="checkbox"/> Operation of crane, truck, tractor, or motor vehicle      | <input checked="" type="checkbox"/> Hearing (aid permitted)                 |
| <input type="checkbox"/> Light carrying, under 15 pounds                | <input type="checkbox"/> Ability for rapid mental and muscular coordination simultaneously    | <input type="checkbox"/> Hearing without aid                                |
| <input checked="" type="checkbox"/> Straight pulling (____ hours)       | <input type="checkbox"/> Ability to use and desirability of using firearms                    | <input type="checkbox"/> Specific hearing requirements (specify)            |
| <input checked="" type="checkbox"/> Pulling hand over hand (____ hours) | <input type="checkbox"/> Near vision correctable at 13" to 16" to Jaeger 1 to 4               | Other (specify)   |
| <input checked="" type="checkbox"/> Pushing (____ hours)                | <input type="checkbox"/> Far vision correctable in one eye to 20/20 and to 20/40 in the other | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Reaching above shoulder             | <input type="checkbox"/> Specific visual requirement (specify)                                | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Use of fingers                      | _____   | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Both hands required                 |   | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Walking (____ hours)                |   | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Standing (____ hours)               |   | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Crawling (____ hours)               |   | <input type="checkbox"/> _____  |
| <input checked="" type="checkbox"/> Kneeling (____ hours)               |   | <input type="checkbox"/> _____  |

**4b. Environmental Factors**

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> Outside                        | <input checked="" type="checkbox"/> Electrical energy                          | <input checked="" type="checkbox"/> Working alone              |
| <input checked="" type="checkbox"/> Outside and inside             | <input checked="" type="checkbox"/> Slippery or uneven walking surfaces        | <input type="checkbox"/> Protracted or irregular hours of work |
| <input checked="" type="checkbox"/> Excessive heat                 | <input checked="" type="checkbox"/> Working around machinery with moving parts | Other (specify)  |
| <input checked="" type="checkbox"/> Excessive cold                 | <input checked="" type="checkbox"/> Working around moving objects or vehicles  | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Excessive humidity             | <input type="checkbox"/> Working on ladders or scaffolding                     | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Excessive dampness or chilling | <input type="checkbox"/> Working below ground                                  | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Dry atmospheric conditions     | <input type="checkbox"/> Unusual fatigue factors (specify)                     | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Excessive noise, intermittent  | _____  | <input type="checkbox"/> _____                                 |
| <input type="checkbox"/> Constant noise                            | <input type="checkbox"/> Working with hands in water                           | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Dust                           | <input type="checkbox"/> Explosives  | <input type="checkbox"/> _____                                 |
| <input type="checkbox"/> Silica, asbestos, etc.                    | <input type="checkbox"/> Vibration   | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Fumes, smoke, or gases         | <input checked="" type="checkbox"/> Working closely with others                | <input type="checkbox"/> _____                                 |
| <input checked="" type="checkbox"/> Solvents (degreasing agents)   |  |  |
| <input checked="" type="checkbox"/> Grease and oils                |  |  |
| <input type="checkbox"/> Radiant energy                            |  |  |

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**Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN**

**NOTE TO EXAMINING PHYSICIAN:** The person you are about to examine will have to cope with the functional requirements and environmental factors checked in Part 4 of this form. Please take these, and the brief description of the job duties, into consideration as you make your examination and report your findings and conclusions.

1. Height \_\_\_\_\_ Feet, \_\_\_\_\_ Inches. Weight: \_\_\_\_\_ Pounds.

2. Eyes:

a. Distant vision (Snellen): without corrective lenses: right 20 left 20; with corrective lenses, if worn; right 20 left 20

b. Depth perception Type of test: \_\_\_\_\_  
\_\_\_\_\_ Seconds of Arc

Number correct: \_\_\_\_\_ of \_\_\_\_\_ tested

Interpretation  Normal  Abnormal

c. Peripheral vision Right Nasal \_\_\_\_\_ degrees Temporal \_\_\_\_\_ degrees  
Left Nasal \_\_\_\_\_ degrees Temporal \_\_\_\_\_ degrees

d. What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant?

Test each eye separately.

**Jaeger No. 2 Type**

The President may -  
(1) prescribe such regulations for the admission of individuals into the civil service in the executive branch as will best promote the efficiency of that service; (2) ascertain the fitness of applicants as to age, health, character, knowledge, and ability for the employment sought; and (3) appoint and prescribe the duties of individuals to make inquiries for the purpose of this section.  
(Title 5 U.S. Code 3301)

without corrective lenses:

L \_\_\_\_\_ in. to \_\_\_\_\_ in.

R \_\_\_\_\_ in. to \_\_\_\_\_ in.

with corrective lenses, if used:

L \_\_\_\_\_ in. to \_\_\_\_\_ in.

R \_\_\_\_\_ in. to \_\_\_\_\_ in.

e. Color vision: Is color vision normal by Ishihara or other color plate test?  Yes  No

If not, can applicant pass lantern test?  Yes  No

Can see red/green/yellow?  Yes  No

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**Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN**

3. Ears: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)

Ordinary conversation:

Audiometer in dB (if given) for Right Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

Right Ear \_\_\_\_\_ ;  
 20 ft.

Left Ear \_\_\_\_\_  
 20 ft.

Audiometer in dB (if given) for Left Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. Other Findings: Describe any abnormality (including diseases, scars, and disfigurements). Include brief pertinent history. If normal, so indicate.

- a. Eyes, ears, nose, and throat (including tooth and oral hygiene)
- b. Abdomen
- c. Head and back (including face, hair, and scalp)
- d. Peripheral blood vessels
- e. Speech (note any malfunction)
- f. Extremities (including strength, range of motion)
- g. Skin and lymph nodes (including thyroid gland)
- h. Urinalysis (if indicated)

SP. Gr. \_\_\_\_\_ Sugar \_\_\_\_\_ Blood \_\_\_\_\_  
 Albumen \_\_\_\_\_ Casts \_\_\_\_\_ Pus \_\_\_\_\_

- i. Respiratory tract (X-ray if indicated)
- j. Heart (size, rate, rhythm, function)

Blood pressure \_\_\_\_\_  
 Pulse \_\_\_\_\_  
 EKG (if indicated)

- k. Back (special consideration for positions involving heavy lifting and other strenuous duties)
- l. Neurological (including reflexes, sensation) and mental health

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**Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN**

5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate.

- No limiting conditions for this job
- Limiting conditions as follows:

6. Examining Physician's Name	7. E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	9. Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)

**IMPORTANT:** After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

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**Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER** (if one is available)

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below.

1. Recommendation:

- Hire or retain; describe limitations, if any, here.
  
- Take action to separate or do not hire; explain why.

2. Agency Medical Officer's Name

3. E-Mail Address

4. Address (Including Street, City, State and ZIP Code)

5. Telephone Number

6. Signature of Agency Medical Officer

7. Date (Month, Day, Year)

**FOR AGENCY USE ONLY**

**Part E. TO BE COMPLETED BY AGENCY HUMAN RESOURCES OFFICER**

1. Action Taken:

- Hired or Retained
- Non-Selected for Appointment, or Eligibility Objected To
- Action Taken to Separate

2. Agency Human Resources Officer's Name

3. E-Mail Address

4. Address (Including Street, City, State and ZIP Code)

5. Telephone Number

6. Signature of Agency Human Resources Officer

7. Date (Month, Day, Year)